## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/23/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  LYNCHBURG NURSING CENTER  SUMMANY GTATGHENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  A COVID-19 Focused infection Control Survey was conducted by the State Agency on September 21, 2020. The facility was found to be in compliance with 42 CPR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 57.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  LYNCHBURG NURSING CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  A COVID-19 Focused Infection Control Survey was conducted by the State Agency on September 21, 2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to		445279		B. WING			09		
F 000 INITIAL COMMENTS  A COVID-19 Focused Infection Control Survey was conducted by the State Agency on September 21, 2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to					40 f	NURSING HOME ROAD			
A COVID-19 Focused Infection Control Survey was conducted by the State Agency on September 21, 2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to	PREFIX	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE				D BE	COMPLETION	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 Focus was conducted by 8 September 21, 202 in compliance with control regulations CMS and Centers 6 Prevention (CDC) r prepare for COVID	sed Infection Control Survey the State Agency on 20. The facility was found to be 42 CFR §483.80 infection and has implemented the for Disease Control and recommended practices to -19. Total census 57.		000				

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PR AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445279	B. WING	B. WING			09/21/2020
NAME OF PROVIDER OR SUPPLIER  LYNCHBURG NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 40 NURSING HOME ROAD LYNCHBURG, TN 37352				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Survey was conduct September 21, 202	sed Emergency Preparedness sted by the Sate Agency on 0. The facility was found to be 42 CFR §483.73 related to	EO	00			
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	_	TITLE		(X8) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED		
TN6401		B. WING		09/21/2020			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
LVNGUB	URG NURSING CEN	40 NURSI	NG HOME R	ROAD			
LYNCHB	URG NURSING CEN	LYNCHBU	JRG, TN 373	352			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	BE COMPLETE	
N 000	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		N 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE